IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

DONNA J. THOMAS, ADMINISTRATRIX OF THE ESTATE OF ANDRE THOMAS, DECEASED, ON BEHALF OF THE ESTATE OF ANDRE THOMAS,	)	
Plaintiff	)	Civil Action No. 09-996
V.	)	Judge Nora Barry Fischer
BOROUGH OF SWISSVALE, DEBRA LYNN INDOVINA-AKERLY, JUSTIN LEE KEENAN and GARY DICKSON,	)	**JURY TRIAL DEMANDED**
Defendants	)	

DEPOSITION TRANSCRIPT EXCERPTS

OF

KARL E. WILLIAMS, M.D.

EXHIBIT 3

TO

PLAINTIFF'S MOTION TO EXCLUDE EXPERT TESTIMONY OF DEBORAH MASH, PH.D. AND ANY EVIDENCE REGARDING AN ALLEGED CONDITION REFERRED TO AS EITHER EXCITED DELIRIUM, AGITATED DELIRIUM AND/OR DRUG-INDUCED DELIRIUM

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

- - -

DONNA J. THOMAS, Administratrix of the Estate of ANDRE THOMAS, Deceased, on behalf of the Estate of ANDRE THOMAS,
Plaintiff,
vs.
BOROUGH OF SWISSVALE; DEBRA LYNN INDOVINA-AKERLEY; JUSTIN LEE, KEENAN; and GARY DICKSON,
Defendants.

Civil Action
No. 2:09-cv-996-NBF

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DEPOSITION OF KARL E. WILLIAMS, M.D.

THURSDAY, AUGUST 4, 2011

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DEPOSITION OF KARL E. WILLIAMS, M.D. called as a witness by the Plaintiff, taken pursuant to Notice of Deposition and the Federal Rules of Civil Procedure, by and before Ronda J. Weinell, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Pennsylvania, at the Office of the Medical Examiner of Allegheny County, 1119 Penn Avenue, Pittsburgh, Pennsylvania, commencing at 1:54 p.m. on the day and date above set forth.

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pathology.
Q. Now, it is fair to say that you have not investigated or written any articles, peer-reviewed or otherwise, dealing with the issue of what we can call excited delirium?
A. I gave one presentation up in Western Psychiatric Institute in 2008 about a case that I performed as an autopsy here that was an unusual case. I used that case to present to them an overview of excited delirium.
Q. What is excited delirium?
A. Excited delirium does not have a specific medical diagnosis that everyone agrees on, so it's hard to say exactly what it is.
Q. Now, yesterday we talked with Dr. Mash.
A. Correct.
Q. That you referred certain frozen specimens, I believe, of Andre Thomas's brain to her.
A. That's correct.
Q. For examination.
A. That's correct.
Q. She told us that the largest study that she was familiar with -- and it may not be a study. It may be

actually a collection of information -- was a group of 90 individuals, and it was published in the medical literature. Do you have any current recollection of being familiar with reading that study or reading that article?
A. I have no idea exactly what study you're talking about. There's been a lot of studies written about excited delirium.
Q. She told us yesterday that, essentially, more than 90 percent of all of the excited delirium cases she was associated with were in-custody, police death situations. Is that your understanding, as well?
A. 90 percent sounds high. We've had cases in this office where we find people dead at home in their environment and believe that there was a case of excited delirium independent of any involvement with the police.
Certainly, since the excitation, the excited state of the person often happens in public, a large percentage of those wind up coming to the attention of the police. I wouldn't say 90 percent.
Q. Here's the main problem with your definition you just gave, and from what she told us, the only way

you can diagnose excited delirium is based upon the witness to the event of the excitement telling you what the person was doing.
A. I don't agree with that.
MR. HAMILTON: I'm going to object to the form of that question, too.
MR. MESSER: Subject to verification.
Q. You don't agree with that?
A. Well, if we don't have -- I mean, Dr. Mash feels that she has a very specific diagnosis, because she bases it on getting frozen sections of the brain. Well, if you find somebody dead in an apartment, you're not going to send the brain to Dr. Mash.
The case that I had at Western Psych occurred without any police involvement, but with issues that were the same thing because of the caregivers at Western Psych. Clear case of excited delirium, but not involved with police, but in this case involving an eyewitness. It's all over the place.
If I don't have a definition of excited delirium and there is no uniform definition of excited delirium, how can you say 90 percent is this, 80 percent is this, 70 percent is this?

Q. I understand. It's a whole big, fat moving target as far as medicine is concerned.
MR. HAMILTON: Object to form.
Q. Is that true?
A. It has not been characterized in a way that the scientific community agrees on the definition. Let me say that.
Q. It is true that the American Medical Association has not accepted excited delirium, any definition of it? True?
A. I don't know that one way or the other.
Q. Are you aware that the Royal Canadian Mounted Police did a study of excited delirium and rejects it as a diagnosis, as a syndrome, or as a disease?
A. I was not aware of that. Is that in their TASER task force, or is that specifically their excited delirium --
Q. Excited delirium, separate task force.
A. I don't know of that report.
Q. Are you aware, sir, of any other groups that have either published or written journal articles critical of the, quote, "excited delirium," end quote, issue?

A. I am sure that there are.
Q. Is it my understanding of what you just testified to that there may be certain psychiatric issues like mania, delirium, and otherwise that fall within what you might consider to be excited delirium?
A. It's an interesting entity, and the DiMaio book, which you must be aware of, has most of the information, if that's still current. There were cases of agitated delirium of a very chronic nature before the advent of psychotropic medications. People would die of what is called Bell's mania. It was called a lot of different things; okay?
And with the advent of Thorazine and the psychotropics in the fifties, those cases kind of died out. Now we're seeing what DiMaio says is a different manifestation of the same syndrome currently. So the entity may have a very long medical history associated with it.
Q. If it is an entity?
A. I believe it's an entity.
Q. A lot of people don't.
A. I don't know how many do or don't. It is one of the most controversial areas in forensic pathology,

for sure.
Q. Why is it only confined to men?
A. I don't know that it is.
Q. Well, the expert yesterday said that over 90 percent of the victims of excited delirium are men.
A. I would not characterize Dr. Mash as an expert in excited delirium. She is not a physician, to begin with, and she's got a very unique population group, which is out of Miami. All of her studies are out of Miami and largely associated with the cocaine using group in Miami. So I don't know that she is an expert in excited delirium.
I think that her study is very interesting. I think that you can take information from that. But I don't know that she's necessarily the expert in excited delirium.
Q. Well, what she essentially told us was that -- and these are subject to verification -- what I believe she told us was that over 90 percent of the victims of excited delirium in her purview were male, and of those 90 percent, over 90 percent were African American male.
So my question is has it been your experience

here in connection with Mr. Thomas's case that the same information is true, that most of them are African American men that have been diagnosed as being dead as a result of excited delirium?
MR. HAMILTON: Object to the form.
Q. I mean do you understand?
A. I understand exactly what you're saying. My numbers are significantly smaller. Again, Dr. Mash is dealing with Miami, with a completely different demographic population in Miami.
I've looked at the cases coming through here, including a couple right before I became medical examiner, and we're only talking about a half a dozen or eight cases or so. But probably half of those are white, are Caucasian, and although you raise an interesting point about males, because I don't know that I've seen a female case, and I don't know the literature.
Q. Well, what she was referring to down there was the abstracts that she had gathered from all over the country. This wasn't just -- but, anyway, let's move along.
At some point in time, you became involved with

the investigation, I believe, and the subsequent autopsy and report regarding Mr. Thomas, Andre Thomas?
A. Yes.
Q. Is that true? And somebody made a decision in the office to send frozen brain samples, I think, as she identified to Dr. Mash.
A. That's correct.
Q. Who did that?
A. It was probably a joint decision of Dr. Shakir and mine. We both were aware that the test had been used previously in this office a couple of times, so we knew it was available, and in a case of this nature, probably decided to see if it would add any additional information.
Q. And they were sent?
A. Correct.
Q. And then she prepared a report that was ultimately sent back to you, I believe?
A. That's correct.
Q. I'm not sure how much -- may I look at that?
A. Sure. It's in there. It's the last part of it.
Q. By the way, one question I keep asking people,

decision then to send these studies to Dr. Miller --
MR. PUSHINSKY: Mash.
Q. I'm sorry. Dr. Mash to perform an analysis?
A. Correct.
Q. All right. And that analysis, I believe you have one of your original copies.
MR. MESSER: Could you mark this Exhibit No. 2, please.
(Deposition Exhibit No. 2 was marked for identification.)
Q. Do you have your copy in front of you, sir?
A. I do, yes.
Q. Now, in this report she goes through a whole statistical computation of things she explained to me yesterday, and I still don't understand. Did you understand what she has done here statistically in the creation of this report?
A. My interpretation of this, especially after talking to her, is that she believes that she can, by an analysis of the high-affinity and low-affinity cocaine binding sites in the particular area of the brain, she believes that she can tell the difference between a case of pure excited delirium, if you will,

or excited delirium, as opposed to those cases where the cause is more delirium and an agitation caused by cocaine rather than -- and, again they're all precipitated by cocaine. They're all in chronic users of cocaine. So it's a very subtle kind of analysis.
That was one of the reasons we decided to send it to her, just to be able to have some additional idea in our mind -- okay -- about what -- because there are no tests for excited delirium. I'm not sure hers -- remember, she's the only one that's doing this.
So I know it appears in peer-reviewed literature, but her test is not necessarily universally accepted as a proof of excited delirium, either. Okay? So --
Q. Well, you don't accept it as a proof, do you?
A. I take her test as I take any other laboratory test, as another piece of information that I use to feed into the whole puzzle of the final wording of a death statement.
So there are very few individual tests -- you know, if I've got a glucose of 550, I know what I'm dealing with. Measuring high- and low-affinity

cocaine receptors in the putamen when she's the only one that's doing it, I'm not fully sure about it, what to do with that, and I haven't had time to review the literature to see if there are people that criticize it statistically, criticize it, many other viewpoints.
Q. I understand. What I understand what you're saying is if you get a blood analysis back, it's reliable. I mean, if they say there's a certain percentage of alcohol in the blood, you would rely upon that report. But whenever you consider a report such as this one from Dr. Mash, you consider it, but you have your own independent ability to make determinations about whether or not you're going to accept all of it, part of it, or some of it. Is that fair?
A. That's fair.
MR. HAMILTON: Object to the form.
Q. Now, in this report she talks about we have demonstrated a marked increase in HSP1AB.
A. Right.
Q. Do you know what that is?
A. A heat-related protein of some sort in the brain.

Q. Right. Now, do you know what part that plays in the analysis of excited delirium?
A. One of the -- and it's more particularly noted in Miami with her studies, maybe because it's hotter in Miami. I'm not sure. But one of the clinical correlates of excited delirium can be hyperthermia, increased body temperature, even leading to the breakdown of muscle and rapid myolysis, which she probably mentioned, also.
So it's like anything else in an event of this nature, what you have, what don't you have, what is the clinical history, is here cocaine there, what else is there.
These are extraordinarily complex cases to sort out.
Q. What faith do you have in the HSP1AB analysis?
A. I've never heard it used in any other case other than her using it in cases of excited delirium. So I don't know what else it might be used with in the scientific literature and what else it might indicate.
Q. But this is the only way you've heard it used here, in excited delirium?
A. I have to say I haven't come across any other

area of forensic pathology where it's of any utility so that I've thought of using it. I presume, like any other substance, it's well researched, well validated, and animal studies have been done. I'm sure that it's real. I just don't know its significance other than Dr. Mash saying that it's got a twofold increase. It doesn't help me any more than the clinical picture, the finding of the cocaine or anything else.

Q. She also indicates that the metoprolol -- that's M-E-T-O-P-R-O-L-O-L --

A. Metoprolol.

Q. Right.

A. Yes, she was fascinated by that when I talked to her. And I think her thinking has probably progressed, since this is 2008. I'm sure she's got more information on that. I was interested in it, because as I said, I had a 20-year-old head injured Caucasian male at Western Psych that also had psychotropic medications but not cocaine and things that had a full blown appearance of what I would call agitated delirium.

The brain studies were not done. Probably did not have all of the pattern of cocaine receptors and

things. Okay?

So it's well known that it can occur with other medications than cocaine. Certainly, it can occur with other amphetamine-like medications, PCP or other drugs that are analogs that act the same way as cocaine, but also other drugs that have a completely different method of action.

Q. Why don't you tell me what you remember about your conversation with Dr. Mash, and tell us when it occurred.

A. That's about all I remember. I've said it. It was 2008. It was specific to this report. And I'm left only with a couple of impressions. One is that she felt it was not clear that the studies at that time proved the entity of excited delirium, whatever her criteria for that was, but she felt more that it was, as we said, an agitated delirium due to the cocaine in obviously a user that has evidence of prior cocaine use, another part of her report, and had a clinical history of a previous similar event some months before; and also that she was curious about the presence of the metoprolol as something that might have interacted with the cocaine that might have been

another contributor to the timing of the event.

Q. So what I understand basically from what you're saying is that she differentiated between excited delirium and agitated delirium and said that this was a case of agitated delirium versus excited delirium; true?

A. I don't know that she used the words agitated delirium as opposed to what she says, perhaps, in her report. Doesn't she say cocaine associated --

Q. She says drug-induced delirium.

A. Drug-induced delirium, cocaine-related. She uses the phrase cocaine-related delirium. See down in her --

Q. Where are you pointing, sir?

A. I'm looking down in her table. She's got categories of excited delirium and categories of cocaine overdose. Although in her narrative, she refers to cocaine-related delirium.

So as I'm noticing it now, there is a little bit of a discrepancy between her narrative -- okay -- well it's not explicit in there that she's making that differentiation. She is not a doctor, so she doesn't give us a diagnosis. So she may read her report with

a different meaning in it from the interpretation I took from speaking with her. So she's not really completely explicit in this report.

If she reviewed it now three years later, she might have a different feeling about it. "The review of the incident report suggests that the decedent was suffering from a drug-induced delirium prior to death." And that's all she really commits to in that specifically.

So she does not, in her report, claim to be able to tell in this particular case that it is an excited delirium. Again, in her table she says excited delirium, and there's values for excited delirium. And I don't know what her definition is for those 60 cases of excited delirium from looking at this.

Q. Right.

A. And none of her references seem -- the fourth paper in here references -- the fifth with Wetli and her name on it is the principal paper from 1996, is one of her earlier studies in that. And I don't know whether -- I don't know whether she and Dr. Wetli define excited delirium specifically in that. So

there's some holes in here.
Q. Holes?
A. Well, in the lack of specificity of the report itself to try to figure out what she's saying. If you look at the last column of this Table 1, and you see the top number of 206.1 for our case —
Q. Yes, sir.
A. — and you see the control and you see excited delirium. Okay? And then you look down at the bottom for cocaine overdose, you'll see that the number is right in that range. If you look over — so showing out of the range for what she defines in that last column for excited delirium, but in the range that she defines for cocaine overdose, almost right in the middle, almost exactly.
If we go down for the high-affinity cocaine site, which is the second column, with the Allegheny County Medical Examiner at 48, excited delirium then is 7.8, and cocaine overdose is 47.3. My interpretation of that is that those numbers suggest that this is a cocaine overdose.
Q. And not excited delirium?
A. And not excited delirium.

MR. MESSER: That's all of the questions I have.
MR. HAMILTON: Let me just ask a question.
CROSS-EXAMINATION
BY MR. HAMILTON:
Q. The August 5, 2008, report is signed by you and Dr. Shakir?
A. Correct.
Q. Can you tell us how this works. Did he do the actual physical autopsy? Did you participate in it with him? Can you tell us, to the extent you have independent recollection or these documents help you, how this works. You signed that report.
A. I countersign every report that goes out of the office, so that's the easy part in that. I have a recollection of being in the autopsy room for this, as I almost all was, and if it's a case that appears to be something that's going to be of specific interest.
I actually go in the autopsy room almost every day that I'm here just to look for those cases. In a case of death in custody as this is, I'll always try to be there, just to know that I've seen the findings in the case.

Q. Now, whether you were actually there or how much time you were in the room where the autopsy was conducted or not, do you, as a matter of course, or did you, as a matter of course with Dr. Shakir, discuss the anatomic diagnoses that are listed above before both of your signatures were affixed to the report?
A. I don't in all cases. In this case I certainly do remember having discussions about it with him.
Q. So to the extent that there are opinions expressed in the autopsy report from the medical examiner in the case of Andre Thomas, they're opinions of yours and Dr. Shakir's?
A. Yes.
Q. And some of those opinions are listed on the August 5 report, the bottom of which has your signature; correct?
A. That's correct.
Q. Cause of death?
A. A cocaine intoxication, agitated delirium as the clinical manifestations of a cocaine intoxication.
Q. And can you explain what that means. I mean —
A. Well, as I said, cocaine is an extremely toxic

drug, can result in sudden cardiac death due to arrhythmias, due to bleeding, due to increased blood pressure. And we know that it can, as many drugs can, lead to a psychiatric state manifested by extreme delirium. That, in and of itself, can kill you.
As a case, like I say, where someone was found in an apartment, closed apartment, the apartment completely disorganized, trashed, as if it had occurred in a state of agitation, him dead and finding cocaine in his body, so do I need to witness that to know that that's a case of agitation due to cocaine? No. I don't feel that I really do.
It's a known manifestation of cocaine. Most of the cases, whether you call it excited or agitated delirium, are associated specifically with cocaine or other amphetamine-like drugs and then a smaller percentage to the other drugs. It's just a well-documented association, clinical manifestation in a certain number of cases of cocaine.
Q. And if I heard you correctly, none of the actual physical findings, external and internal examination, this portion of the autopsy, not the lab reports —